DOCUMENT RESUME

ED 055 273 AC 010 870

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TITLE The Performance of Paraprofessionals in the Mental Health Field.
INSTITUTION New York Univ., N.Y. New Careers Development Center.
PUB DATE Jul 71
NOTE 26p.; Prepared for the American Handbook of Psychiatry, 1971

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS Hospitals; *Indigenous Personnel; *Mental Health; Mental Health Clinics; *Paramedical Occupations; Patients (Persons); Professional Personnel; Research Reviews (Publications); *Role Perception; *Subprofessionals

ABSTRACT

A major concern of this article is to document the role of paraprofessionals in providing services for clients in the mental health and psychiatric fields. There are basically three types of paraprofessionals. The first type is the "old" hospital worker; he does not have a college degree, is not indigenous to the community in which he is working, comes from a low income background, is frequently Black or Puerto Rican, and does supportive therapeutic work. The second is typically a woman with a degree, generally engaged in substantive therapeutic work, and, mainly, white. The third is the indigenous paraprofessional who does hold a degree, is generally employed, and is engaged in therapeutically relevant work. A wide range of data on these professionals was collected. Although no one of the studies conducted is conclusive by itself, a number of them such as the Ellsworth study are well controlled and offer powerful evidence. However, the multiplicity of evidence derived from a great variety of different sources, stemming from different investigator biases, using diverse methods and indices, leads to the conclusion that paraprofessionals play an important role as treatment agents and contribute to the improved mental health of clients and patients in highly significant, often unique ways. (Author/CK)

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THE PERFORMANCE OF PARAPROFESSIONALS IN THE MENTAL HEALTH FIELD

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July, 1971

AC010876

Prepared for The American Handbook of Psychiatry, 1971

Edited by Gerald Caplan

The Performance of Paraprofessionals in Mental Health Fields*

Our major concern in this article is to document the role of paraprofessionals in promoting service for clients in the mental health and psychiatric fields; that is we are mainly interested in the practice of the paraprofessional as it relates to the functioning of the patient or consumer.** Although he plays other roles, (e.g., social change agent, etc.), our focus is on his input to service delivery. As we shall see, a number of major studies provide considerable evidence that the paraprofessional does indeed play a role in contributing to improved mental health of clients and patients both in hospitals and commmunity settings.

Unlike public schools where paraprofessionals are relatively new (although a significant minority of the staff), in the mental health

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* Many terms have been used for the non-credentialled worker: nonprofessional, subprofessional, new professional, paraprofessional, aide, auxiliary, allied worker, community professional, community worker, new careerist, etc. Recently, the term paraprofessional seems to be most widely accepted and is the one we shall use throughout the article, although many of the workers themselves are beginning to prefer "new professional."[2]

** There is a huge and rapidly growing literature concerning paraprofessional programs in general, as well as mental health programs in particular. Illustrative is the recent publication of a bibliography on paraprofessional programs which contains well over a thousand items."[41]

programs, they are of long standing and comprise a large majority of the employees.

Consideration of the role of paraprofessionals in mental health must begin first with an identification of just who it is one is discussing. If one defines as professionals those holding post-baccalaureate professional degrees, and excludes those engaged in only maintenance and housekeeping activities, one can suggest three types of paraprofessionals.

The first type is what might be called the "old" hospital-based worker. He is typified by the psychiatric aide working in a hospital setting, engaged in supportive therapeutic work. He usually does not have a college degree and is not indigenous to the community in which he is working, although he generally comes from a low income background and is frequently Black or Puerto Rican.

The new middle class paraprofessional is typically a woman with a degree who has received special training in mental health skills and is generally engaged in substantive therapeutic work. Margaret Rioch's program is perhaps best known in this area. The women she trained were middle class, mainly white, and held previous college degrees.

Finally, there is what has been called the indigenous paraprofessional who is recruited from the community where he works. He is usually employed, although not exclusively, in mental health centers, does not hold a college degree and is engaged in therapeutically relevant work.

The first type, the "old paraprofessional" is, of course, the most common and the heart of the staff of mental health hospital facilities. The "new paraprofessional" is seen in the various efforts of the late 1950's and 1960's to meet professional manpower shortages, while the "indigenous paraprofessional" is largely the child of the anti-poverty

and community mental health efforts. It is the last two to which we will give special attention.

The "Old" Paraprofessional

A highly significant well controlled experiment conducted by Ellsworth indicates that the old type of paraprofessional can play a powerful role in the improved treatment outcome for hospitalized male schizophrenics.[10] "A demonstration project in which the focus was on treatment was the development of the psychiatric aide as the rehabilitation agent", conducted at the Fort Meade, South Dakota, V.A. Hospital. Fort Meade is a 600 bed hospital; for the purposes of the demonstration the patients of one building were used as an experimental group (n=122) and patients of two other buildings as a control group (n=214). For patients in both groups, the program was similar in use of medication, use of activity group therapy, the process of reaching decisions as to discharge, assignment of new admissions, and patient characteristics.[11]

The demonstration program was designed to raise the level of aide-patient interaction. To do this effectively, the role of the aide in the hospital had to be altered, particularly as relates to participation in decision-making.

A higher percentage of the experimental group patients were released to the community during the thirty-month demonstration period, and a lower percentage of them had to return to the hospital.[12]

Post-discharge outcomes were based upon seven indices:

Level of behavioral adjustment;

Median days subsequently hospitalized;

Released vs. not released;

Percent achieved twelve consecutive months in community;

Good social adjustment;

Discharge status six years later.

For the twenty-one pairs of comparisons (the experimental and control were each divided into three sub-groups each depending upon degree of schizophrenia) the experimental group did better on all twenty-one; in thirteen of them at a substantial level of significance.[13] "Although the chronically hospitalized patients group profited most by the approach used in the experiemental program, the acute group of patients also responded significantly."[14]

The key factors in the aides' role seemed to be in the increased interaction with patients and the aides participating more actively in decisions regarding patients. And the two factors inter-connected "as the active involvement of the aide in the decision-making process was found to be a necessary condition in sustaining aide-patient interaction."[15]

Ellsworth concludes

> Our project has shown clearly that the role of a nonprofessionally trained person can be modified extensively in a psychiatric rehabilitation setting. When this modification takes the form of actively involving the nonprofessional in all phases of patient rehabilitation the treatment outcome for hospitalized male schizophrenics is highly significant.[16]

The New Paraprofessional

Perhaps best known in this area is the early work of Margaret Rioch[54] and the studies of Carkhuff and Truax. Both these investigations, as well as a number of others reported in this section, provide evidence regarding the effectiveness of paraprofessionals as treatment agents.

In 1960, the Adult Psychiatry Branch of NIMN funded Rioch's Mental Health Counselors program.[53] It was designed to fill the need for staff to provide low-cost psychotherapy and at the same time provide useful work for women with grown children. The value of these women was seen in

their successful child-rearing experience and maturity. Eight women were chosen from among eighty who sought applications. Their median age was 43; seven were married, one widowed; they had an average of 2.4 children; all were college graduates, three had post-baccalaureate degrees; six had held professional jobs; four had been psycho-analyzed; all of their husbands held executive or professional positions. Their upper-class status is further shown by their ability to participate in a two-year training program without pay, with no guarantee of a job at the end.

All eight women completed the four semesters of training which empahsized professional breadth, not technician specificity. It was limited to psychotherapy, and emphasized on-the-job training. Most of the patients of the trainees were adolescents.

Blind evaluation by outside experts of tapes of interviews of trainees (not identified as such) with clients were conducted. On a scale from 1 (poor) to 5 (excellent), the rating of the interviews on eight factors ranged from 2.7 (beginning of interview) to 4.2 (professional attitude), with an overall global impression mean score of 3.4.[54]

Evaluation of patient (n=49) progress showed that none changed for the worse, 19% showed no change; and 61% some change -- 35% slight improvement, 20% moderate improvement, 6% marked improvement.[55]

As to the counselor's faults, the director reports "they pleasantly reassure, protect and sympathize when it would be better to question more deeply and seriously. A second fault is a tendency to try to deal on a surface, common sense level with problems that are soluble only by eliciting unconscious conflicts."[56]

Similar to the Mental Health Counselors program in terms of the background of the women trained as counselors, the Child Development Counselors program at DC Children's Hospital differed from Rioch's program in that

the counselors worked with patients of a different class background.[9] A similar cross-class effort was involved in by Davidoff et. al.'s in Albert Einstein College of Medicine Mental Health Rehabilitation Workers project which also used mature women,[8] as did a Rochester, New York, program where housewives worked with emotionally disturbed young school children.[83] The many programs using college students as therapeutic agents crossed both class and age lines.[7, 28, 29, 39, 51] Still other programs use peers as therapeutic agents.[24]

In Australia, paraprofessional part-time volunteers (mature adults, successfully married) provide marriage counselling service. Some 270 persons serve approximately 15,000 persons per year. The volunteers receive weekly training for about a year and a half, primarily in a non-directive client-centered Rogerian approach. In about 15% of the cases the problem was solved, and in aother 25% of the cases marital relations were noticeably improved, according to Harvey.[27]

Aides trained in Rogerian "play therapy" worked with six Head Start children diagnosed by a psychologist as in need of psychotherapy due to uncontrollable withdrawn, and inhibited behavior. "All six children treated by the aide showed signs of improvement during the treatment period," as reported by Androvic and Guerney.[1]

Similar to these efforts is the work at the Arkansas Rehabilitation Research and Training Center led by Charles Truax. Here the effort has been to identify those characteristics which make for more effective counselling, and for the use of lay counselors. Two major experiments are of interest. The first compared the work of lay therapists, clinical psychology graduate students and experienced therapists.[66] It involved 150 chronic hospitalized patients. "The variety of current diagnoses included manic depressive reactions, psychotic depressive reactions, and schizophrenic... ."[67] Patients were randomly assigned to lay persons who

had 100 hours of training, clinical psychology graudate students and experienced counselors. "The lay mental health counselors were able to provide a level of therapeutic conditions only slightly below that of the experienced therapists and considerably above that of graduate student trainees."[68]

Earlier work of the Arkansas group had isolated three factors as critical to therapists' effect upon patient: his communicating a high level of accurate empathy, non-possessive warmth, and genuineness to the patients. There were no significant differences between the three groups of counselors as related to communicating accurate empathy or non-possessive warmth. On the third factors, communicating genuineness to the patient, the experienced therapists showed significantly higher performance.

Summarizing the effect upon patients of the work of the lay therapists, Truax, the project director, wrote

> Research evaluation indicated highly significant patient outcomes in <u>overall improvement, improvement in interpersonal relations, improvement in self-care, and self-concern, and improvement in emotional distrubance.</u>[69] (Emphasis in the original.)

The second study conducted at the Arkansas Center addresses more closely the effect of paraprofessional counselors. Some 400 patients, at the Hot Springs Rehabilitation Center, a large residential center, were randomly assigned in three different groups: 1) to experienced professional MA degree) counselors; 2) to experienced counselors assisted by an aide under maximum supervision; and 3) to aides (former secretaries with little if any college but 100 hours of training) working alone under supervision. Within each of the three patterns, caseload was varied at either thirty or sixty; thus, there was a 3 x 2 experimental design. Two-

thirds of the patients were male; two-thirds white; all had personality of behavioral problems, and a sizeable number had speech and hearing defects, or were mentally retarded.[75]

Performance under the three patterns of staffing was measured based upon

-- client work quantity;

-- client cooperativeness;

-- client work attitude;

-- quality of client work;

-- client dependability;

-- client ability tc learn;

-- overall client progress.

On all measures,

The best results were obtained by the aides working alone under the daily supervision of professional counselors. The professional counselors working alone had the second best results, while the counselors plus the aide had the poorest effects upon clients.[76]

The greater positive effects on client rehabilitation by the aides with their own caseload appeared to be "due both to the somewhat higher levels of warmth and empathy communicated bo the clients by the aides and the greater motivation and enthusiasn of the aides."*[73]

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* The aides spent more time with clients, especially when they had high caseloads. The professionals, when they had high caseloads spent less time with clients. The aides, in effect, appeared to feel that it was necessary to work hard to get to all the cases, while the professionals seemed to feel that with so many clients to see, what is the use. However, "Overall, neither the total number of minutes spent in contact with individual clients nor the frequency of client contacts was related to the client vocational progress."[72]

Carrying their conclusions beyond this project, the authors state

> The findings presented here are consistent with a growing body of research which indicates that the effectiveness of counselling and psychotherapy, as measured by constructive changes in client functioning, is largely independent of the counselor's level of training and theoretical orientation.[77]

Summarizing his review of many of the programs described above, Garfield concludes, "The implication of all the programs. . . is that counselors can be trained in a clinical setting, in a reasonably short time, to perform a variety of functions."[20]

The broadest examination of the work of paraprofessionals in mental health is Sobey's study of over 10,000 paraprofessionals in 185 NIMH-sponsored programs.[57] As the data are presented in gross categories, one cannot, for the most part, distinguish the particular type of paraprofessional being employed, although it would seem that they include persons from all three of the groups we have delineated above -- the "old" paraprofessional, and the indigenous paraprofessional.

The major finding relates to the reason for the use of paraprofessionals

> Nonprofessionals are utilized not simply because professional manpower is unavailable but rather to provide new services in innovative ways. Nonprofessionals are providing such therapeutic functions as individual counselling, activity group therapy, millieu therapy; they are doing case finding; they are playing screening roles of a non-clerical nature; they are helping people to adjust to community life; they are providing special skills such as tutoring; they are promoting client self-help through involving clients in helping others having similar problems.[58]

The basis for the use of paraprofessionals is illustrated in Table 1 by the responses of project directors to the question of whether, given a choice of hiring professionals, project directors would prefer to utilize paraprofessionals for those functions which professionals had previously performed.[59]

In short, 54% perferred to use paraprofessionals over professionals for tasks previously performed by professionals, or to put it another way, only 32% preferred to use professionals.

As could be anticipated from the above,

> Overwhelmingly the project directors felt that the service performed by nonprofessionals justified the expense of training, supervision and general agency overhead.[60]

The directors saw paraprofessionals contributing across a broad spectrum of program activities including servicing more people, offering new services, and providing the project staff with new viewpoints in regard to the project population.[61] Table 2 displays the directors' sense of these contributions.

The response to the last item in Table 2 relating to "new viewpoints" suggests that a significant number of the paraprofessionals were indigenous workers. Also, in sixty-nine projects the directors reported expanding the professional's understanding of the client group through association with the paraprofessionals.[62] The same thrust is to be seen in the comment that "the introduction of nonprofessionals was perceived as infusing the projects with a new vitality, and forcing a self-evaluation which although painful, led to beneficial changes for the field of mental health."[63]

The work style and personal attributes of the paraprofessionals was important, as they brought

> a change in atmosphere within the agency, and more lively and vital relationships among staff and between patients and staff... . Improved morale, better attitudes toward patients, definite improvement in over-all quality of service were other improvements reported. The addition of youthful, untrained personnel within several hospitals make the older trained personnel re-examine their own roles and the role, structure and function of the entire hospital.[64]

In summary,

> Nonprofessionals were viewed as contributing to mental health in two unique ways: (1) <u>filling new roles based on patient needs</u> which were previously unfilled by any staff; and (2) performing parts of tasks previously performed by professionals, but <u>tailoring the task to the nonprofessionals' unique and special abilities.</u>[65] (Our emphasis.)

The value of the use of new paraprofessionals is summarized by Carkhuff, a former staff member of the Arkansas Center.

> In directly comparable studies, selected lay persons with or without

training and/or supervision have patients who demonstrate changes as great or greater than the patients of professional practitioners.[3]

The Indigenous Paraprofessional

The characteristics of the lay counselor, as described by Carkhuff,[4] appear to apply as well to the indigenous worker.

(a) The increased ability to enter the millieu of the distressed;

(b) The ability to establish peer-like relationships with the needy;

(c) The ability to take an active part in the clients' total life situation;

(d) The ability to empathize more fully with the clients' style of life;

(e) The ability to teach the client, from within the clients' frame of reference, more successful actions;

(f) The ability to provide clients with a more effective transition to more effective levels of functioning within the social system.

One of the earliest uses of indigenous paraprofessionals was at Howard University of the "Baker's Dozen" project with Jacob Fishman,[18, 19] Lonnie Mitchell,[37, 38] and colleagues. The Howard team's work has continued both here and at the University Research Corporation whose many reports include consideration of mental health programs, primarily as part of New Careers efforts.[40, 42]

A 1969 survey of eighty community mental health centers found that 42% of all full-time positions were filled by indigenous workers. The figures were higher in drug abuse treatment (60%) and geriatric service (70%).[43] A study in the same year, of paraprofessionals in ten community

mental health centers in New York City reported their "actual work as described by administrators varied from unskilled to highly skilled but more often is of the highly skilled variety."[21] The work included

-- interviewing,

-- escort service,

-- home visits,

-- manning storefront office,

-- receiving complaints,

-- collecting information,

-- acting as translators,

-- performing individual and group counselling,

-- organizing community meetings,

-- leading therapy group,

-- assisting patients in self-care,

-- acting as patients' advocates with other agencies,

-- casefinding,

-- screening applicants,

-- making case conference presentations,

-- doing casework,

-- giving speeches,

-- planning after-care services,

-- giving supportive psychotherapy to ex-patients.[22]

Reiff and Riessman make the point that the use of the indigenous paraprofessional is part of the new concern for service to the poor. If concern is only to meet professional manpower shortages, indigeniety is unnecessary. However, if there is a concern to reach and serve those unreached and unserved, in short, if the propelling motive grows out of a critique of service performance, then the indigenous worker may be needed.[47] The ability of the indigenous paraprofessionals is "rooted in

their background. It is not based on things they have been taught, but on what they are."[48] They are poor, from the nieghborhood, minority group members, their family is poor, they are a peer of the client with common language, background, ethnic origin, style, and interests.* They can establish special relations with clients -- the paraprofessional "belongs", he is a "significant other", he is "one of us". His life-style is similar with that of the client, especially "the tendency to externalize causes rather than look for internal ones."[49]

Hallowitz, the co-director of the pioneering Lincoln Hospital Mental Health Services Neighborhood Service Center program, describes a range of activities for the indigenous worker in such a setting.[25] These include:

-- expediting,

-- being a friend in need,

-- sociotherapy,

-- supervised work,

-- services to post-hospital patients,

-- services to the disturbed in the community,

-- self-help.

The Lincoln Hospital Mental Health Services Neighborhood Service Center program began with an OEO grant, January 1, 1965. Three centers

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* Perhaps the ultimate in the use of the indigenous worker is an NIMH-funded project to train twelve Navajo males as medicine men. They are to learn the fifty ceremonies of tribal traditions for treating illness and to work with the Public Health Service doctors re. referrals and assistance.

were established, each staffed with five to ten aides. They were seen as "bridges" between the professionals and the community. They are expediters, advocates, and counselors. Something of the power of their impact and the need for services in a community such as the South Bronx is shown by the service figure of 6,500 persons seen at two of the centers in the first nine months. As the program offered services to the clients' whole family, it was estimated that over 25,000 persons were effected during that period.[51]

Harlem Hospital has employed indigenous workers in a variety of roles. Harlem residents interested in working with the aged, provided outpatient geriatric psychiatric services. They made home visits, provided escort services, observed and reported upon patient behavior, provided social services. About half of the study group of sixty cases were successfully managed.

Especially innovative is June Christmas' Harlem Hospital Group Therapy Program, which uses indigenous aides.[4] The aides work in a half-day treatment program for a small group of chronic psychotic post-hospital patients. The aides participate as co-therapists in weekly group psychotherapy sessions, act as participants and expediters in the monthly medication group meetings, are members of the weekly therapeutic community meetings, and lead the weekly client discussion groups. In addition, they perform case services, family services, home interviews, survey patient needs, and provide community mental health education.[5] The program was expected to hold one-third of the patients; it has held two-thirds.[78] A four-step career ladder -- trainee, worker, technician, specialist -- is in effect, gained, in part, through the efforts of union Local 1199 of the Drug and Hospital Workers Union.[41]

The Temple University Community Mental Health Center has trained indigenous workers as Mental Health Assistants, workers who they describe

as "helpers first, then therapists".[30] Over time a work pattern developed where the Mental Health Assistants "function as a 'primary therapist' providing on-going treatment and continuity of care which would include the procurement of ancillary (professional) services whenever appropriate."[31] The Assistant, a title the workers themselves preferred to "aide", worked with 96% of the patients in the clinic's first year. Two key factors in their work involved "holding" patients and by their availability preventing hospitalization.

> While the percentage of patients' attrition between initial contact and first appointment is still high, it is a lower rate than that presented for comparable patient aggregates in usual clinic settings. The need to hospitalize patients contacting the crisis center and clinic has decreased by 50% due to the Assistants' availability for immediate outpatient care.[32]

The Central City Community Mental Health Center in Los Angeles, uses community workers in a program designed to develop additional mental health manpower, train new workers, improve understanding between the disadvantaged and mental health personnel, and increase the available services and create new services appropriate to the disadvantaged. The community workers are used in the mental health facility itself, at a family service center, in various social welfare agencies, in a public health project, in a public housing program, and to provide crisis intervention therapy in a suicide prevention program.[45]

Among the other uses of indigenous paraprofessionals in mental health programs is as alcoholism counselors in a program of the Baltimore County Health Department; as paramedic technicians at a state residential school for the mentally retarded in Hawaii; as part of a home treatment team at at the V.A. Hospital in Tuscaloosa, Alabama; in a child guidance clinic component of a comprehensive mental health center in Rochester, New York.

Formal Education and Performance

In a far reaching study of seventeen state rehabilitation agencies, involving 209 counselors, 50 supervisors and 1,502 patients, the ratings of supervisors and patients were correlated with four levels of worker education -- post MA, MA, BA, less than BA.

> [H]igher levels of academic training of rehabilitation counselors do not result in higher supervisor ratings on the dimension of overall affectiveness of the counselor.
>
> [H]igher levels of academic training for rehabilitation counselors do not result in higher client reports of satisfaction with his counselor.[17]

The lack of correlation between formal education and work performance has been cited in many of the reports described above. It may be that the type of formal education presently offered does not lead to improved paraprofessional performance because, as we have seen, training of untrained people has led to improved performance. New training approaches are beginning to develop at the college level.

Something of a new approach is being developed in the new mental health college programs. An NIMH grant, in 1965, inaugurated at Purdue University the first two-year training program for mental health workers.[79] This was followed in 1966 by a Southern Regional Education Board conference on the role of community colleges in mental health training. In 1967, two Maryland community colleges began such programs,[77] and by September, 1968, twenty-six community colleges were offering similar programs, and fifty-seven in 1970. The programs emphasize practicum, interviewing skills, counselling, use of community resources, techniques of behavior medification.[80]

In evaluating the Purdue progeam, various effects have been noted as regards changes in patient care -- "humanizing" the hospital, opening

closed wards, establishment of patient government, more use of recreation and work facilities, use of new treatment modalities such as milieu therapy and sociotherapy.[25]

These developments offer some counter-vailint tendencies to the finding of the survey of New York City community mental health centers described above, that despite the fact that 70% of the center administrators rated the paraprofessional contribution as "Essential" and another 22% rated it "Highly Desirable," there is "little thought given toward developing the paraprofessional job into a worthwhile one."[23]

And, perhaps encouraging is the fact that the graduates of the new Purdue program while working in mental health programs have chosen not to do so in traditional mental health facilities. It may be, as the authors suggest, these new workers are disillusioned with the traditional medical model of mental health services.[81]

The tensions involved between new personnel, new training, and traditional mental health practices has been well captured in a far reaching article by Minuchin. He points out that initially the use of paraprofessionals in mental health grew out of the manpower shortage.

> For many professionals, a very important major assumption was implicit in this strategy; that we could maintain intact the traditional conceptualizations of mental illness and treatment, simply fitting the nonprofessional into the already existing structure of delivery of service.
>
> But the inclusion of paraprofessionals in the existing structure of delivery of service brought to a head a bipolarity of approaches to mental illness which was already incipient in the field.[33]

At the one pole where sociological thinking dominated, where pathology is seen as coming from the "outside in," paraprofessionals have had less

difficulty in fitting in. On the other pole, when the individual is very much a separate human being, the problem of fitting in has been very much greater. The paraprofessionals are seen as doing little more than "implementing the professional's recommendations and their supervision."[34]

Minuchin's answer is that the field itself must be changed, indeed the very relationship of individual and society reconceptualized.[35] As we have seen, the paraprofessional, initially introduced in a narrow framework, has -- in one way or another -- become a force for and focus around changes of a basic nature in the field. It is these changes, rather than minor tinkering within the present structure, which may be the shapers of the paraprofessionals' future role in mental health.

Summary

A wide range of data on traditional "old" paraprofessionals working in hospitals, new middle class paraprofessionals, and indigenous paraprofessionals, all indicate in various ways that paraprofessionals can play a role in the rehabilitation and treatment of patients. Probably no one of these studies is conclusive by itself, although a number of them such as the Ellsworth study is well controlled and does offer rather powerful evidence. But rather the point is that the miltiplicity of evidence derived from a great variety of different sources, stemming from different investigator biases, using diverse methods and indices, leads to the conclusion that paraprofessionals play an important role as treatment agents and contribute to the improved mental health of clients and patients in highly significant, often unique ways.

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